The Need for Transformation in Health Care Administration

Report on the administrative component of the Saskatchewan Patient First Review

Prepared by Deloitte

October 2009

Patient First

Glossary of Terms

Term	Description
ADM	Assistant Deputy Minister
AHA	Athabasca Health Authority
BI	Business Intelligence
Current Regional Structure or Service Providers	14 service delivery organizations include the following: 12 Regional Health Authorities, Athabasca Health Authority, and Saskatchewan Cancer Agency
DM	Deputy Minister
ED	Executive Director
eHR	Electronic Health Record
ERP	Enterprise Resource Planning
FTE	Full Time Equivalent
GA	General Administration
HISC	Health Information Solutions Centre
HR	Human Resources
IT	Information Technology
JJE	Joint Job Evaluation
LOS	Length of Stay
LTC	Long-Term Care
MCP	Management Compensation and Classification Plan
MIS Guidelines	Management Information Systems Guidelines
Newco	New Company
Non-urban RHAs	RHAs beyond Saskatoon Health Region and Regina Qu'Appelle Health Region
North RHAs	Athabasca Health Authority, Keewatin Yatthé Regional Health Authority, Mamawetan Churchill River Health Region
PREMIS	Business Intelligence Tool
QBS	Quality as a Business Strategy
RHA	Regional Health Authority
RQHR	Regina Qu'Appelle Health Region
Rural / Urban RHAs	Prairie North, Kelsey Trail, Heartland, Sunrise, Cypress, Five Hills, and Sun Country
SAHO	Saskatchewan Association of Health Organizations
SCA	Saskatchewan Cancer Agency
SHR	Saskatoon Health Region
SMO	Senior Medical Officer
SUN	Saskatchewan Union of Nurses
The Province	The Government of Saskatchewan
Urban RHAs	Regina Qu'Appelle, Saskatoon Health Regions and Saskatchewan Cancer Agency

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July 17, 2009

Mr. Tony Dagnone, Commissioner,
Saskatchewan Patient First Review

Deloitte is pleased to provide the *Report on the Administrative Review Component of the Patient First Review*. To begin, Deloitte would like to recognize the Government of Saskatchewan's leadership and commitment to understand the challenges in today's health care system, and then take action to make improvements.

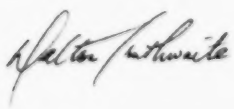
The attached Report is the culmination of seven months' effort. During this time, Deloitte has worked closely with Ministry of Health staff, and you to design and deliver this review. In my role as Engagement Partner for this project, I have been part of the core project team and have worked closely with them to digest the findings, summarize the key results, and identify change opportunities that are appropriate for Saskatchewan.

As you will read in this report, the Administrative Review is not just about identifying what is wrong with the system, but rather about building on strengths, understanding causes, and identifying ideas for improvement. In partnership with you and the Ministry of Health staff, we have worked hard to answer the longstanding question related to whether the health care system is 'over-' or 'under-managed' and offer solutions that adhere to the government's 'commitment to action to improve the system'.

This report provides evidence supporting the need for change. It is important that the current political, government and health system leadership of Saskatchewan not overlook the ever-present reality that very little in today's world remains as it was a few decades ago. Saskatchewan and its health care system are not exempt from this global phenomenon. This Government has undertaken a landmark review to improve the system. This report begins the change journey. It will take leadership, commitment and courage.

Throughout this project, we have come to build and enjoy a good and close working relationship with you and the Ministry of Health staff. It has been a privilege to support this critically important initiative to advance the health care system in Saskatchewan.

Sincerely,



Dalton Truthwaite
Principal,
Deloitte Inc.

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Introduction

The Government of Saskatchewan (hereafter called the Province) and the health regions, or regional health authorities (hereafter called RHAs), continue to play a critical role in building and delivering the health care services for Saskatchewan. However, the leadership of the Province and the RHAs will continue to face pressures. Rising costs of care, increasing demand, and the availability and sustainability of the administration workforce are some of the key constraints for which there are neither quick nor easy solutions. Compounding these challenges, citizens expect continued, if not higher, levels of service in spite of these constrained resources. The gap between what is desired and what can be delivered is growing, and will only widen in the current health service delivery environment if changes do not occur. This is the current and growing dilemma for Provincial and RHA leaders.

Within this challenge are the seeds of powerful transformation, which the Province recognizes. Shortly after the election in the fall of 2007, the new government committed to undertake a system-wide Patient First Review of the provincial health delivery system. This commitment is identified as a priority in the November 2007 Mandate Letter for the Minister of Health by the Honourable Brad Wall, the Premier of Saskatchewan. As part of the broader Patient First Review, and with a view to "direct dollars away from bureaucracy" to support enhanced care, the Province through the Ministry of Health (the Ministry) undertook an Administrative Review, which included an assessment of baseline administrative resourcing of RHAs, affiliates, Saskatchewan Cancer Agency, and the Saskatchewan Association of Health Organizations (SAHO).

In seeking to transform the current health care system, there are at least four compelling drivers for examining the administrative component of health care delivery as one of the key elements of the Patient First Review. First, an aggregate view of the health system management provides a unique opportunity to explore innovation and change at the system level, rather than focusing on the individual regional health authority level. Second, the management system is an important player in service planning, decision-making and delivery for patients and communities. Third, the management system today is experiencing the same workforce sustainability challenges evident in the clinical care areas and should be exploring alternative options to maintain quality, efficiency and effectiveness. And finally, the resources allocated for management structure should be dollars well spent, deliver value to the system, and ultimately the patients and communities served. Given the objective of the Administrative Review was to ascertain current levels and determine optimal levels of administrative support for the system, this review has examined the question of whether the current health system is 'over' or 'under' managed, and has identified change opportunities that reflect four key value drivers: patient focus, workforce focus, system focus and overall feasibility.

This review reports on how Saskatchewan's health management system compares to other Canadian jurisdictions, and also highlights the current and future sustainability challenges. Through this review, the report does raise the question of value in terms of effectiveness and efficiency of the current regional health structure and its corresponding administrative system. While there are strengths in the system, there are significant challenges. To close the widening gap between expectations, requirements and capabilities, the Province and RHAs will have to acknowledge and endorse a new course of action to manage Saskatchewan's health care system. There are good reasons to change, however, deep change takes time, and suggests urgency for action to allow time for detailed and proactive planning to successfully reshape the management system.

Implicit in the recommendations in this report, Provincial and RHAs leaders must avoid the false notion that the Saskatchewan health sector is too unique, different or constrained to adopt innovative and creative solutions seen in the broader public sector, other health jurisdictions and the private sector. The inevitable conclusion in this report is that the future of Saskatchewan's health system does not lie with the status quo. The transformation opportunities identified are intended to deliver positive outcomes that focus on more effective management, and will ultimately deliver better service and address the sustainability challenges facing many management teams across many of the Regional Health Authorities. An additional and significant benefit in embracing the recommended change is the coming together of RHAs as a common enterprise for select areas of management, rather than a collection of independent entities. The future reduced costs can be used as an offset to the required investment to support the change and, in time, can be re-allocated to the patients and communities of Saskatchewan.

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Project Overview

Background

Deloitte was engaged by the Province to conduct the Administrative Component of the Patient First Review, which included an assessment of baseline administrative resourcing of all health regions, or regional health authorities (RHA)s and affiliates, Saskatchewan Cancer Agency, Health Information Solutions Centre (HISC) and Saskatchewan Association of Health Organizations (SAHO). The overarching purpose was to identify if the administrative component of the health system is 'over' or 'under' managed. The areas of focus for this review (the scope) where both qualitative assessment and comparison with other jurisdictions occurred, included: General Administration (GA), Finance, Human Resources (HR), and Information Technology (IT). In the qualitative and comparative analysis, the objectives were to:

- Identify current levels of administration support;
- Determine optimal levels of administration support;
- Identify if the current structures are over or under resourced;
- Assess enablers and barriers of system effectiveness; and
- Identify improvements or alternatives that could enhance system value.

In addition, Telehealth and Nursing Management were two further areas for review that were primarily qualitative in nature:

- Telehealth encompassed a review of utilization related to clinical, education and administrative applications, and an identification of areas for improvement; and
- Nursing Management assessed the current span of control issues and identified enablers and barriers for Nurse Manager effectiveness in acute care and integrated health facilities, followed by improvement opportunities. The Project Sponsors recognized the challenge in excluding the community, long term care, public health and home care sector for this component of the review. However, given the budget limitations, and the belief that findings from the review would be applicable to all sectors, the focus was the acute domain with the agreement to share the acute findings with the remaining sectors to explore alignment and relevance.

It is important to note that the intent of this review was to assess the management function and resourcing at a province-wide level. While the review began by understanding the relevant areas in each RHA as well as other relevant provider entities, such as SAHO, SCA and HISC; individual provider information was combined to provide an aggregate baseline for comparison against other jurisdictions. This macro approach offers Saskatchewan a 'big picture' understanding, and was intended to drive opportunities for system benefit rather than focusing at the individual RHA provider level.

Due to the province-wide focus of the review, and the strong linkage to administration functions, the area of supply chain management was considered within the review.

Limitations

The findings through this review do not report information at the RHA or affiliate level. In particular, affiliate data at the RHA level was part of the RHA summary data that was further aggregated for a provincial picture. The aggregate nature of this review provides findings that may stand in contrast to comparative analysis conducted at the individual level RHA. This is an important consideration when RHAs compare the results against their own individual benchmarking exercises conducted in other reviews.

External scan participants provided a wide range of information to support Saskatchewan's change journey. However, the sensitive nature of some of the provided information and intended direction for their jurisdiction prevents disclosure of their identity.

This report is intended for internal use by the Ministry of Health and the Government of the Province of Saskatchewan; it is not designed for external purposes or third parties. This document is to assist in the development of future planning, budgeting, funding and reporting requirements for health services in Saskatchewan.

The recommendations are based on data collected and validated, analysis conducted, and consultations with key stakeholders. Deloitte is not responsible for updating the analysis or the report following the submission of this report.

Consulting Process

There were four phases in this project. All phases of work were supported by consultation and collaboration with the Patient First Commissioner – Mr. Tony Dagnone, and Project Lead for the Ministry of Health.

Phase 1 – Project Launch and Planning provided the foundation for the Review and focused on: confirming the project scope and workplan, developing a detailed stakeholder engagement strategy, planning the consultation sessions, distributing program profile questionnaires to participating organizations and a data request to the Province for information available centrally (i.e. strategic / operationally plans, financial and payroll information, etc).

Project kick off meetings were held to confirm project scope, approach, timelines, responsiblities, and data requests.

Phase 2 – Current State Assessment focused on a combined quantitative and qualitative process conducted in following areas: 13 RHAs (including Athabasca Health Authority), SAHO, SCA, HISC. At the Service Provider level, the focus was on the specific areas of: General Administration, Finance, Human Resources, Information Technology, Nursing Management (acute and/or integrated facilities) and Telehealth. While no affiliates were interviewed (see below), affiliates within the current RHAs were included within the quantitative analysis. Understanding the delivery of these services at the respective provider level was key before rolling up data to conduct province-wide analysis for General Administration, Finance, Human Resources, and Information Technology. For the Nursing

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Management and Telehealth work streams, there was a focus on the current barriers for effectiveness and required enablers for improvement.

Given SAHO's role in procurement for the Province, and the material relevance of Supply Chain as a corporate support function, high level analysis of Supply Chain was undertaken, although this was not in scope for a detailed review at the RHA level. Potential opportunities related to supply chain were considered given the natural linkages to the Finance function through accounts payable, and the provincial group purchasing function supported by SAHO.

The following methods were used to provide an understanding of operating context as well as to validate accuracy of the administrative baseline.

Qualitative research and analysis

- Consultations with leadership and management across:
  - RHAs, SCA, SAHO, HISC
  - A sample of 5 RHA-selected affiliate leaders selected from across the province
  - A sample of 6 current / exiting board chairs
  - Leadership in the Ministry of Health (Assistant Deputy Minister and Executive Director level)
- Profiles relevant to General Administration, Finance, Human Resources, Telehealth and Information Technology were completed by RHAs, the Cancer Agency and SAHO in advance of the consultation, and were used to augment the interview process
- Web-based survey of 226 Nurse Managers in acute and integrated care facilities to gain insights on their span of control issues with a 51% response rate
- Focus groups with Nurse Managers to understand their span of control and related operational challenges. Interviews with Directors and Clinical Vice-presidents were also conducted to further validate the scope of the Nurse Manager role, and the associated challenges.
- Literature review on Nurse Management span of control
- Management focus groups as internal customers of Finance, Human Resources, Information Technology and General Administration services
- Review of relevant background documentation (Strategic Plan, Performance Reports, etc) provided a basis for consultation meetings
- Identification of strengths and challenges related to current processes, practices and requirements were documented through consultation

Data analysis and validation

- Application of national reporting standards (i.e. Management Information System (MIS) guidelines) for the purposes of internal trending and external benchmarking;
- Validation of RHA and Cancer Agency data facilitated by the Ministry's MIS coordinator
- Inclusion of HISC, SAHO, and Cancer Agency relevant costs for provincial roll-up data analysis;
- Comparison of Saskatchewan to the following Canadian jurisdictions: British Columbia, Alberta, Manitoba, Ontario, Nova Scotia, New Brunswick, Newfoundland and Labrador; and

- Internal trending / analysis, where data was grouped as follows:
  - Saskatchewan-wide – all entities;
  - Urban – Saskatoon Health Region, Regina Qu'Appelle Health Region, Saskatchewan Cancer Agency;
  - North – Athabasca Health Authority, Mamawetan Churchill River RHA, and Keewatin Yatthé Health Region; and
  - Rural/Urban – All other regional health authorities (8).

External Scan

(interviews and research of other Canadian and international jurisdictions) to further inform comparative analysis, identify trends and gain insights on key issues relevant to Saskatchewan:

- On completion of the consultation and high level data analysis, the project team identified key issues of focus for inclusion in the external scan;
- Key issues of focus and other jurisdictions for inclusion were validated with the Project Sponsors and Patient First Commissioner. Topics included alternate service delivery models and benchmarking; and
- Interviews were conducted with leaders (either in RHAs or in other Canadian Provincial Ministries of Health) across British Columbia, Alberta, Ontario, and New Brunswick. Through Deloitte's 'Knowledge Exchange' and network of health care industry leaders globally, additional research was conducted that included Manitoba, Nova Scotia, the United States, the United Kingdom, and Denmark.

Phase 3 – Opportunity Assessment and Identification involved the presentation of findings and opportunities for Saskatchewan's health system to the Project Steering Committee.

The consulting process included a two-step process. At the first Steering Committee meeting, preliminary findings and opportunities were presented. The opportunities were categorized as enabling and transformational. For several of the transformational opportunities, additional analysis was conducted and the results presented at a second Steering Committee.

This two step process allowed the Steering Committee time for reflection on the findings and opportunity areas, as well as additional high level analysis to determine the preferred direction for those areas of significant change (called the transformational opportunities).

Phase 4 – Recommendations and Final Reporting involved the development of draft and final reports supported by the Patient First Commissioner and Ministry feedback. Assessment findings, opportunities, and implementation considerations are included in this final report.

Throughout the lifespan of the Administrative Review, the Deloitte Project Team engaged with respective teams for the Patient Experience Component (KPMG) and the Legislative Secretariat for Nursing Recruitment and Retention. Through such collaboration, the respective projects were able to facilitate information sharing and validation and explore areas of alignment.

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Key Findings and Associated Implications

Combined Corporate Management or "Administration" (i.e. General Administration, Finance, Human Resources, Information Technology)

Saskatchewan's Corporate Management system has much strength to build upon. Over the years, Ministry of Health and RHA leaders have established forums where they convene to collaborate and provide inter-organizational support. Examples of such initiatives include:

- Health Quality Council - applying key lessons from high performing health systems (i.e. Quality as a Business Strategy, Lean, Releasing Time to Care);
- Leadership Forums – CEOs, Chief Information Officers / IT Leaders, Senior Medical Officers, Workforce Planning, Nursing;
- South Regions Forum (comprised of RHAs in southern Saskatchewan); and
- Northern Health Strategy (for Saskatchewan).

Despite these collaborative efforts and successes, challenges within Corporate Management continue to grow. Moreover the resource base and capacity across the RHAs in Saskatchewan is highly variable, thereby creating significant differences in these service providers' responses to the growing pressures in the area of Corporate Management.

Benchmarking Comparison

Metric	Sask-wide	Canadian Peers		
		25th %ile	Median	75th %ile
% of Operating Spend	6.51%	5.80%	6.91%	7.86%
Admin Spend / Health Region (000s)	$12,308	$14,480	$20,940	$80,739

Throughout our consultation, major issues of workforce and fiscal sustainability were raised, in particular amongst the non-urban RHAs across corporate areas (i.e. Finance, HR, and IT).

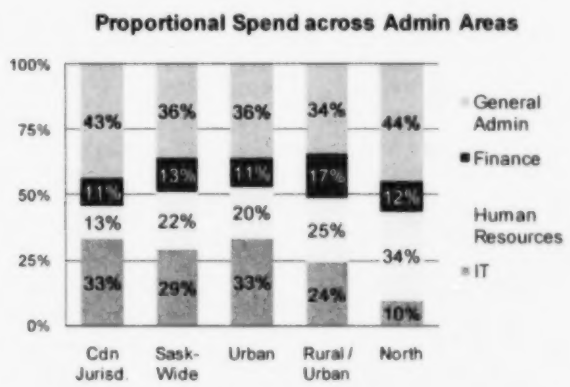
A starting point for analysis was to review the overall combined Administration Spend across the four Administration areas (i.e. GA, Finance, HR, and IT) to determine how these components of Saskatchewan's overall corporate management resourcing compares to other Canadian provinces.

Results show that at a combined level (for all four areas), Saskatchewan is below the Canadian median, which means it is spending less than other Canadian jurisdictions on Administration as a percentage of total operating spending. The combined overall lower percentage of total operating spend for Administration repudiates the concern somewhat that Saskatchewan is spending more resources on Administration than other jurisdictions.

While on the surface, this appears a 'good news' finding, subsequent analysis in this report demonstrates that there are variations in resourcing levels at the discrete functional levels of General Administration, Finance, Human Resources and Information Technology. As health care organizations in Saskatchewan target a 5% Administration spend overall, strategic investments (such as HR to address workforce challenges) require trade-offs in relative investment in other key areas of need (i.e. IT to advance the eHealth agenda). Further discussion on the specific areas will be reported on in the remaining sections of this report.

On closer review of the proportional spend across Administration areas; there is also variation across the province. Compared to other Canadian jurisdictions:

- Saskatchewan's urban RHAs are in line in IT and Finance;
- Saskatchewan's rural/urban RHAs are below in IT and GA, but over in Finance and HR; and
- Saskatchewan's northern RHAs are below in IT, in line with GA and Finance, and over in HR.



Implications

While Saskatchewan shows lower levels of corporate spend when combining all functions (General Administration, Finance, Human Resources and Information Technology) in contrast to other Canadian jurisdictions, this report is not stating that the lower spend represents efficiency and effectiveness.

The consequence of lower relative spend is that Regional Health Authorities in Saskatchewan, particularly in the Non-urban RHAs, are experiencing significant performance challenges (from a customer needs perspective) and sustainability challenges (from a fiscal and workforce perspective). Our consultation indicates that many areas of management support (such as: quality, performance management, decision support, patient safety, project implementation support and strategic human resource management, etc) are not occurring at the level that they should, when compared to the needs of the respective organizations. The inability to provide adequate services in these areas creates real limitations to effective management support and function. Improvements in these corporate management areas across the province, while desirable, are not feasible given the current regional structures and associated resourcing.

Two important questions surfacing from this review for broader provincial consideration are:

- "Is Saskatchewan receiving desired value for its corporate spend on Administration across its multiple RHAs and SCA?"
- "What would a higher value regional model and structure look like for Saskatchewan in terms of more efficient Administration spending?"

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Related to the first question, Saskatchewan would benefit from a future corporate health management structure that achieves a balanced mix of strong, centralized management of Administration, combined with local responsiveness designed to:

1. Create economies of scale through a centralized procurement function and the consolidation of repetitive transactional functions occurring across all RHAs;
2. Promote standardized practices for current and new work processes to enhance effectiveness;
3. Attract and retain required staffing for 'hard to find roles' to avoid the current and anticipated workforce challenges in many of the RHAs; and
4. Provide consistent strategic leadership at a province-wide level.

Such a management transformation of the Administration function is intended to deliver higher value, address sustainability challenges across smaller regions, increase efficiency, and, once in place, costs the system less. Operating dollars saved through transformation can be re-allocated to the patients and communities of Saskatchewan.

In terms of the second question, the Province will require further review and planning in order to design a different regional health model. This review did not examine the current Regional Health Authority structure. Consequently, the comments made in this report relate to the number of RHAs in Saskatchewan and their respective impact on resource distribution in the area of Administration. While 13 entities may align to the geographic dispersion of Saskatchewan's population, economies of scope and service quality related to Administrative services, are hampered by the distribution of a limited pool of resources (i.e. financial and people). Provinces across Canada continuously examine this issue and there are numerous lessons to be learned from Provinces that have embarked on changes to their health care structures.

Finance

In this review, the Finance function included the following areas: Accounts Payable and Receivable, Payroll, Budgeting, General Accounting, Financial Reporting and Planning.

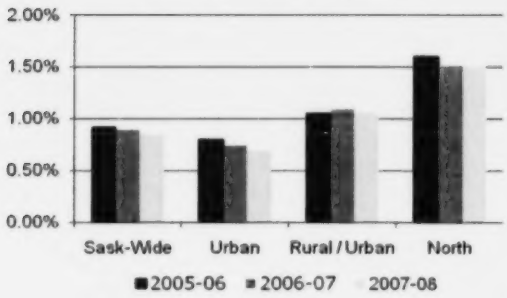
The two charts shown below indicate the spend variation at a function-specific level that deviates from the overall combined trend for all four areas. In the lower left hand table titled, "Year over Year % Operating Spend", the relative spend on Finance has been declining – which indicative of higher relative spending in other areas of the health care organizations (i.e. clinical services).

The second analysis table titled "Benchmarking Comparison" compares Saskatchewan to Canadian jurisdictions. It shows that Saskatchewan's level of resourcing in Finance is relatively higher than peers. Our consultation findings suggest that this variance is driven by:

- Manual processes and lack of automation (i.e. Procure-to-Pay electronic enablement, Business Intelligence tools); and

- The current regional structure of 14 entities – where economies of scale and scope are difficult to achieve given that regions are performing similar functions.

Year over Year % Spend



Benchmarking Comparison

Metric	Sask- wide (07-08)	Canadian Peers (06-07)		
		25th %ile	Med	75th %ile
% of Operating Spend	0.85%	0.63%	0.74%	0.80%
Finance Operating Cost / Org. FTEs	$798	$633	$720	$876
Org. FTEs / Finance FTEs	80	75	90	99

While the current regional structure (meaning the number of entities) may drive the higher provincial benchmark result relative to other provinces, the real challenge is that the non-urban regions are primarily transaction focused with limited ability for higher function requirements. Our analysis indicates that approximately 60% of Finance operating FTEs are in transactional functions (such as Accounts Payable, Accounts Receivable, General Accounting, Asset Management, and Payroll) with limited support capacity to support strategic management (planning / analysis / decision support functions).

Consistent with findings reported in GA, HR and IT, Finance departments also report current and anticipated gaps in recruiting qualified staff. Specifically, eight regions indicated current vacancies, and six regions indicated recruitment challenges of qualified staff. The consequence is that Chief Financial Officer (CFO) and / or Director roles in the non-urban RHAs are often required to perform frontline functions / activities (i.e. decision support and analysis). The larger total operating base for urban RHAs enable Saskatoon Health Region and Regina Qu'Appelle Health Region to build capacity and invest in Finance to support activities such as process automation through Business Intelligence (BI) Tools and Financial Analyst / Business Manager roles. Such resources are, generally, not available to the smaller Regions. However, the maturity level of BI tools is limited by available information – which is primarily financial or payroll based. With limited linkages to statistical / clinical utilization data, budget accuracy, funding, and in-year performance management are impacted – and may not meet the needs of RHAs and the communities they serve. Smaller RHAs have developed manual processes and home-grown tools for performance reporting where managers have to go to multiple sources (including paper-based to access performance reports), which further dilutes manager time and creates the risk of inconsistent reporting.

Also significant is that internal customers of Finance (Managers interviewed in focus groups) report limited Finance department support / capacity to deal with budgeting, planning, and ongoing management throughout the fiscal year. Similarly, support for education and training related to information / tools, and expectations of managers were reported to be inconsistent. Internal customers (i.e. managers) did report that they did not believe Finance

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departments to be purposely unresponsive, rather that workload pressures require Finance staff to prioritize and hence the internal customer needs may not be met in a timely manner.

Given such people and process challenges, it is not surprising that the area of data management is an area of concern across the province. While all organizations have a chart of accounts, data definitions and common accounting policies, there are significant differences across organizations. Such variation makes inter / intra-provincial comparisons a challenging task. For example; in completing this project, more than 300 adjustments were made to Saskatchewan data across RHAs / Other Providers. Quality data, reporting requirements and lack of decision support tools impact the value Finance can deliver to organizations.

While Supply Chain was not in scope, the review did conduct some high level analysis for two reasons: 1) accounts payable has significant linkage to the supply chain function, and 2) group purchasing is a key support function provided by Saskatchewan Association of Healthcare Organization (SAHO) to RHAs. The annual provincial spend on supplies (i.e. medical / surgical, drugs, diagnostics and therapeutics, minor equipment, and capital) was $420 million annually in 2007-08. SAHO group purchase contracts account for 20-25% of spend across both operating and capital spend items. Given the duplication of supply chain functions across the RHAs, and the total annual spend to manage the supply chain function is approximately $13.5 million (i.e. compensation and non-compensation costs to manage the supply chain), this area is worth further investigation in Saskatchewan as an area of potential cost savings. For health care organizations across Canada and internationally, end-to-end supply chain is a key area of focus for service integration, and can offer invaluable lessons for supply chain delivery in Saskatchewan.

Implications

The higher resourcing of Finance relative to other Canadian jurisdictions, workforce sustainability challenges, and the high transactional nature of work, suggest that it is a reasonable candidate to explore the degree to which an alternative service delivery model can deliver efficiency and capacity opportunities.

As well, a similar opportunity for alternative service delivery presents itself related to Supply Chain. Across Canada, many jurisdictions indicate that a positive business case for Supply Chain service integration can support service integration across other corporate and support functions.

Human Resources

In this review, the Human Resource (HR) function included the following areas: HR Administration, Labour / Employee Relations, Occupational Health and Safety, Organizational Development, Talent Management, and Benefits Management.

To meet the people needs of the organizations, Human Resources departments must continually evolve to both meet current human resource requirements, while anticipating and planning for future needs. Traditional HR provided services have not evolved across Saskatchewan to meet these needs, particularly in the non-urban regions. This is further

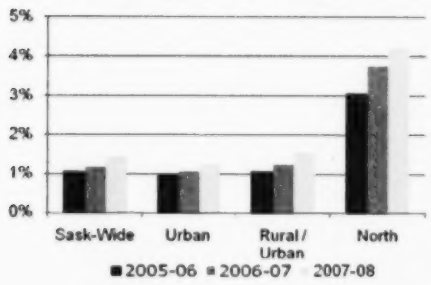
compounded by the lack of an HR information system (HRIS) creating work at many levels of the organization that is paper based and labour intensive.

The two charts shown below indicate the spend variation at a function-specific level that deviates from the overall combined trend for all four areas. In the lower left hand table titled, "Year over Year % Operating Spend", Saskatchewan's HR spend as a percentage of total operating spend continues to increase at a significant and unsustainable rate due to domestic and international recruitment efforts required to keep health care facilities and clinical programs operating.

Further, as shown in the second analysis table titled "Benchmarking Comparison" which compares Saskatchewan to Canadian jurisdictions, Saskatchewan's level of resourcing in Human Resources is relatively higher than peers. Consultation findings suggest that this variance is driven by:

- Significant provincial investment to sustain current clinical programs / infrastructure – through an increased focus on nursing recruitment domestically and abroad;
- Increasing demands placed on HR functions across Saskatchewan's health care organizations to support increased recruitment requirements, and to address employee safety / wellness with an aging workforce;
- Complex collective agreements that reportedly (by management and leadership) requires both local support through Labour Relations advisors (38 FTEs across health care regions) to manage day-to-day operations, and provincial expertise and support through SAHO's provincial Labour Relations team (22 FTEs);
- Manual processes and a lack of automation across HR functions (i.e. a Human Resource Information System currently exists in only 1 RHA); and
- The current regional structure (14 entities) makes economies of scale and scope difficult to achieve.

Year over Year % Operating Spend



Benchmarking Comparison

Metric	Sask-wide	Canadian Peers			Other Jurisdictions & Industries (50th %ile)	
		25th %ile	50th %ile	75th %ile	US Health Care	Banking
% of Operating Spend	1.43%	0.81%	0.89%	0.95%	N/A	N/A
HR Operating Cost / Org. FTEs	$1,341	$699	$892	$1,197	$892	$1,695
Org. FTEs / HR FTEs	104	82	116	118	140	83

Generally, our consultation findings indicate that HR departments have varying skill sets and capacity, which impacts their ability to address strategic priorities. Similar to Finance, the magnitude of the urban RHAs operating bases (specifically Saskatoon and Regina Qu'Appelle Health Regions) allows for a higher level of investment in HR, and enables increased strategic focus, capacity building and investment to support initiatives such as:

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succession planning, leadership development, integrated HR service teams, and workplace culture. However, across much of the province, the current HR service delivery model is not meeting the needs of the growing, complex health environment. Frontline managers indicate that while they receive support from HR across the various functions (i.e. recruitment, disability management, attendance management), the level of support is insufficient. Moreover, HR departments have limited mechanisms to measure or monitor customer service quality, satisfaction and requirements, thereby creating a disconnect between services provided and services needed. Internal customers did report that they did not believe Human Resources Departments to be purposely unresponsive, rather that workload pressures require Human Resources staff to prioritize and hence the internal customer needs may not be met in a timely manner.

SAHO has a significant role supporting the HR function in the province. It provides support for provincial collective bargaining, labour relations expert advisory support, training and other organizational supports for member organizations (such as Career Pathing, Representative Workforce, Occupational Health and Safety). Such shared services provided by SAHO continue to provide value to the system, as reported to us by SAHO's member organizations and the Ministry of Health.

Implications

The higher relative resourcing of Human Resources compared to other Canadian jurisdictions combined with the workforce sustainability challenge, the high transactional nature of work and limited capacity for strategic initiatives suggest that it is a reasonable candidate to explore the degree to which an alternative service delivery model can deliver efficiency and capacity opportunities. Where alternative service delivery models are examined, it will be important to consider and build upon the important provincial HR functions that are currently supported by SAHO.

Information Technology

In this review, the Information Technology (IT) function included the following areas: Help Desk, Network / Infrastructure Support, Application Support, Project Support, Technology Support and Systems Engineering / Development.

Each organization reviewed had an IT function; however, there are various service delivery models in place. Generally, where IT functions in RHAs have not been sufficient to meet business requirements due to a range of issues (such as: recruitment challenges, skill base of current staff, capacity of existing staff, escalating costs to support / enhance infrastructure and processes), the RHAs have adopted alternative service models. For example, two RHAs have contracted with external providers through outsourcing agreements, and three RHAs obtain IT services through a managed service relationship with other RHAs.

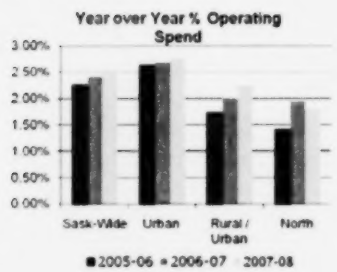
A key component of IT in Saskatchewan's health care is the support provided by Saskatchewan Health Information Network (SHIN). SHIN is a Treasury Board Crown Corporation that is accountable to, and funded by the Ministry of Health. SHIN's mandate is managed and delivered by the Health Information Solutions Centre (HISC), and includes the following key roles:

- Deliver the mandate of an Electronic Health Record for Saskatchewan citizens;
- Support health sector initiatives within the IT domain;
- Provide a secure province-wide health information network, including hosting health care applications centrally through the HISC data centre; and
- Provide information management and technology services to regional health authorities and other health service providers and delivery agencies within Saskatchewan.

While HISC supports all RHAs, non-urban RHAs are larger users of HISCs service offerings.

As part of the comparative analysis (benchmarking) exercise for IT in Saskatchewan, in addition to the Canadian provincial comparison, the review included an assessment of relative investment levels in non-Canadian health care organizations and other industries. US health care organizations and other knowledge-based industries spend more than 5% of their operating budgets on Information Technology (IT). Leading health service organizations in the US indicate that they spend more than 7% annually on IT.

The two charts shown below indicate the spend variation at a function-specific level. In the lower left hand table titled, "Year over Year % Operating Spend", Saskatchewan's IT spend as a percent of total operating spend is increasing. This trend demonstrates the 'catch-up' phenomena.



Benchmarking Comparison

Metric	Other Jurisdictions & Industries (50th)				Sask-wide	Canadian Jurisdictions		
	US Health Care	Banking	Insurance	Govern-ment		25th %ile	50th %ile	75th %ile
% of Operating Spend	5.4%	12.6%	7.1%	6.8%	1.90%	1.87%	2.55%	2.71%
IT Operating Cost / Org. FTEs	N/A	N/A	N/A	N/A	$1,779	$1,751	$2,365	$3,162
IT Operating Cost / Org. Headcount	$10,498	$24,391	$24,823	$11,467	$1,229	N/A	N/A	N/A

In spite of the 'catch-up' trend, as shown in this second analysis table titled "Benchmarking Comparison", Saskatchewan remains below all comparators – either Cana Management section of this report. Further, when examining the relative proportional dian provinces or other international health jurisdictions and industries. This lower spend is a key driver in the lower combined spend result as shown earlier in the overall combined Corporate Provincial spend on capital versus operations, the ratio is 17% (capital) to 83% (operational) for Saskatchewan. This stands as a noted contrast to US health providers whose same ratio is 30% to 70% respectively.

Within Canada, Canada Health Infoway (CHI) recommends 4% annual spend on IT to achieve the potential and desired benefits in quality, access, and productivity. Analysis shows that Canadian jurisdictions, including Saskatchewan, are spending below broader industry averages, and all provinces continue to 'catch-up' regarding spending on IT infrastructure for clinical and non-clinical information systems.

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Saskatchewan's lower comparative analysis results point to the need for continued investment in IT as an important requirement for two important considerations that:

1. Advance the eHealth agenda; and
2. Support the eHealth uptake and stronger business and clinical management among RHAs.

Consultation findings indicate that non-urban RHAs are largely unable to meet business and clinical information needs of their organization and that the levels of IT support and competency is highly variable across the province. Saskatchewan's RHAs report that the 5% cap on administration spending (including GA, Finance, HR, and IT) impacts their decision making ability related to investment in IT – suggesting that administration spending targets may either need to be adjusted (or should exclude IT) to remove perceived barriers to investment and support more accurate reporting. (Note: RHAs have historically been required to maintain Administration Spending within 5% of total operating spend.)

A further concern is that the future situation will be even bleaker where RHAs do not have the IT capacity to support the upcoming clinical transformation needed in moving to an eHealth environment, a stated objective of the Ministry of Health.

Implications

The Province will have to overcome its IT investment fatigue and recognize that, in spite of funding support in recent years, it continues to under-invest in IT. Additional support is required to advance the eHealth shift as well as support enhancement of clinical and business process requirements for the RHAs.

Future investments should be grounded in both:

- eHealth Strategic plan (which is underway) to guide Provincial and RHA priorities; and
- Defined RHA requirements for operations (business, information and clinical).

The Province should avoid the distributed service model seen in Finance and HR where there is duplication across regions, recruitment of qualified staff is a challenge and the limited critical mass furthers service and sustainability pressures. These challenges are only to be repeated in IT where RHAs attempt to build their own enhanced IT service response.

Looking forward, the role of HISC remains pivotal, however further review is required to determine changes at the HISC level in terms of how it supports RHAs and other organizations in the system (mandate, roles, services offered). Moreover, through consultations, a need was identified by stakeholders for stronger coordination and collaboration in IT strategy development, service planning and implementation.

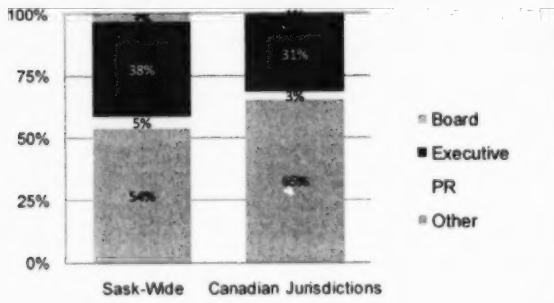
General Administration

In this review, the General Administration (GA) function includes the following areas: Executive, Board, Public Relations, Infection Control, Strategy / Planning / Decision Support, Quality, Risk, and Patient Safety.

The two charts shown below provide results at a function-specific level. In the lower left hand table titled, "Proportional Operating Spend by Area", Saskatchewan is spending more proportionally on Boards and Executive Management. The higher spend on Executive and Board is driven by non-urban RHAs, and is related to the relatively small total operating costs over which GA costs are spread. In dollar terms, the annual spend for Boards is reported to be $1.7M annually. In addition to this dollar cost, there is significant time and effort spent by executive teams (i.e. RHA CEO's, VPs, and CFO's) related to Board support.

Further, as shown in this second analysis table titled "Benchmarking Comparison" which compares Saskatchewan to Canadian jurisdictions, Saskatchewan is spending less in this area than other provinces. The consequence of lower spend in GA means fewer available resources in non-urban regions for key support functions, such as: strategic planning, decision support, quality, risk, patient safety, corporate project management support, medical affairs, infection control and the sustained implementation of provincial initiatives.

Proportional Operating Spend by Area



Benchmarking Comparison

Metric	Saskatchewan	Canadian Peers		
		25th %ile	Median	75th %ile
% of Operating Spend	2.30%	2.82%	2.99%	3.55%
Operating Cost / FTE	$2,131	$2,565	$2,699	$3,734
GA Spend / Health Region (000s)	$4,371	$7,323	$10,168	$33,518
GA Spend / Capita	$60	$59	$65	$71

Consultation findings suggest that challenges in attracting and retaining executives at the RHA level will continue as approximately a quarter (or 26%) of this group are eligible for retirement in 5 years. Moreover, the review found that there are limited succession strategies in place to address this high level of turnover.

Additionally, recruiting physician leadership is challenged in the non-urban RHAs given that these roles are only part-time (0.2 to 0.5 FTE across most non-urban regions), and have limited support or capacity for activities, such as physician recruitment / retention and resource planning, quality of care initiatives, enforcing standards of care / practice, physician performance management and accountability.

Implications

The lower relative GA spend has consequences for RHAs in Saskatchewan, particularly amongst the non-urban RHAs where there is limited ability to invest in the areas of performance management, quality, patient safety, risk management and decision support. These limitations converge to create performance, accountability and sustainability challenges.

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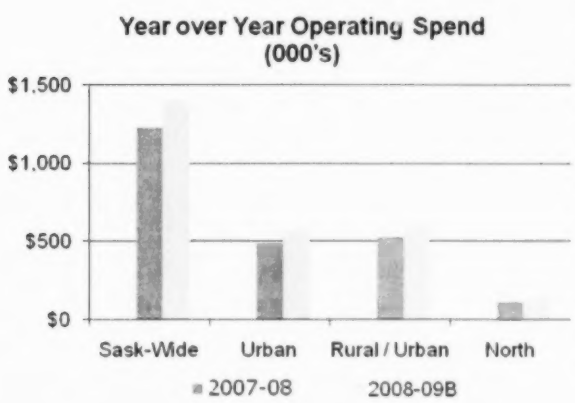
The requirements to provide robust levels of management support across the larger number of health regions would be cost prohibitive. Moreover, the value in duplicating these resources across all RHAs is questionable suggesting the need for future review of the overall regional model.

Regardless of the number of RHAs, current management teams should assess the requirements of their senior management teams to ensure the best allocation and distribution of resources – where reallocation of resources should consider requirements to enhance quality, safety, access, and ultimately, the patient experience.

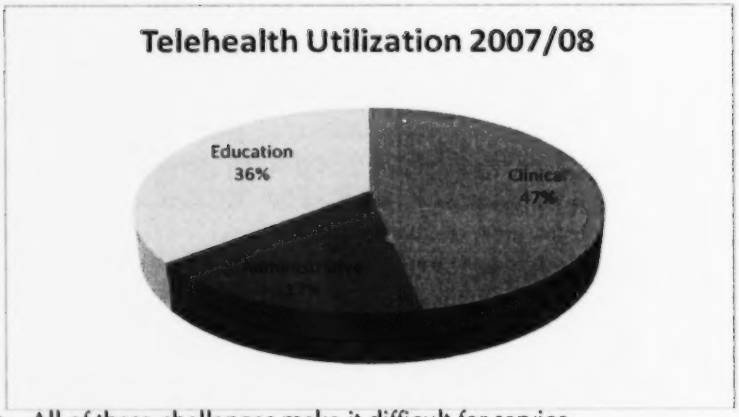
Finally, Physician leadership challenges require leader and support roles at the RHA level beyond the current level of resource investment to increase capacity for key activities such as physician resource planning, quality of care initiatives, and physician performance management and accountability.

Telehealth

Telehealth enables the delivery of health related services and information through the application of telecommunications. Telehealth in Saskatchewan is a provincial program that is currently part of HISC, and has been in place since 2004. Key objectives include: Improved access to health services and health care providers; Enhanced rural practice support; Encourage optimal use of health care providers; and Provision of continuing education and health information to patients and the public. Both provincial and RHA investment in capital equipment (i.e. Telehealth suites and technology) and Telehealth operations (i.e. Telehealth coordinators in each RHA) has fostered continued growth in the program. As shown in graphic (above), year over year operating spend from 2007-08 to 2008-09 increased 14%. Analysis of data (not shown) indicates that Telehealth sessions (all types) have increased to approximately 4000 in 2007-08, which is more than double since 2004-05.



While use and investment in Telehealth is growing, there is high potential for continued expansion for clinical, education, and administration utilization. Within Saskatchewan, Telehealth continues to be an under-utilized resource to support alternate service delivery models for patient care, as well as staff education and management / administrative uses.



The graphic (at right) outlines the distribution of Telehealth use by type: 47% for clinical (patients), 36% for staff education, and 17% for administrative (meetings and teleconferences). This shows that clinical utilization represents nearly half of the all the Telehealth utilization, which is a good direction. Notwithstanding the gains, there are reported challenges with coordination, scheduling and delivering clinical sessions, and limited staff and technology resources. All of these challenges make it difficult for service expansion. Where Telehealth continues to be cumbersome from a physician / clinician perspective, this technology will have sustainability challenges – where physicians will discontinue use of Telehealth in favor of more traditional clinical care (i.e. in-person consultations).

Implications

Telehealth is a key enabler to increasing access to specialty services across a province like Saskatchewan – which has large geography, dispersed populations, and challenges recruiting specialists to non-urban areas.

This area of review has a more direct linkage to the Patient Experience review. More specifically, Telehealth can continue to address some of the reported access challenges that were highlighted in focus groups across the province.

Both capital and operating investment is required to sustain and expand Telehealth use in Saskatchewan, and to design and support work processes (i.e. scheduling coordination) and technologies (i.e. desktop video conferencing, video archiving) that will make it easier to access / use.

Seamless applications of Telehealth from a care perspective, without time / financial impacts to physicians, are key requirement for increased clinical uptake by physicians. Success in this application will support other Telehealth applications being used in other jurisdictions (i.e. tele-home care, telemonitoring) that can be considered.

Nursing Management

The Nursing Management focus in this review was to gain a better understanding of span of control issues, as well as the enablers and barriers for Nurse Manager effectiveness in acute units and integrated health facilities (acute and long term care).

Our findings reveal nursing management roles in Saskatchewan, like the rest of Canada, have evolved over the past two decades. The graphic (below) highlights the nature of the shift in Saskatechwan.

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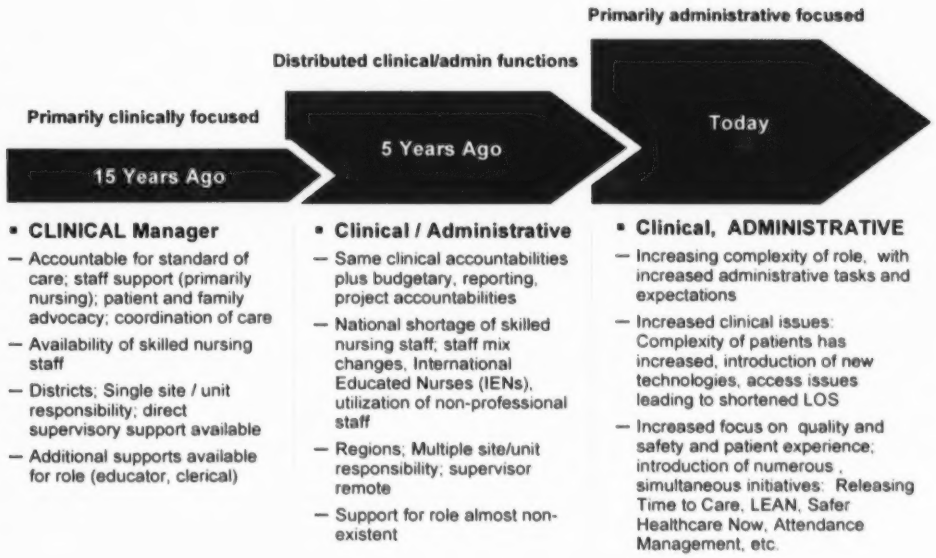
Evolving Nature of Nursing Management


Primarily administrative focused
Distributed clinical/admin functions
Primarily clinically focused
15 Years Ago
5 Years Ago
Today
• CLINICAL Manager
– Accountable for standard of care; staff support (primarily nursing); patient and family advocacy; coordination of care
– Availability of skilled nursing staff
– Districts; Single site / unit responsibility; direct supervisory support available
– Additional supports available for role (educator, clerical)
• Clinical / Administrative
– Same clinical accountabilities plus budgetary, reporting, project accountabilities
– National shortage of skilled nursing staff; staff mix changes, International Educated Nurses (IENs), utilization of non-professional staff
– Regions; Multiple site/unit responsibility; supervisor remote
– Support for role almost non-existent
• Clinical, ADMINISTRATIVE
– Increasing complexity of role, with increased administrative tasks and expectations
– Increased clinical issues: Complexity of patients has increased, introduction of new technologies, access issues leading to shortened LOS
– Increased focus on quality and safety and patient experience; introduction of numerous , simultaneous initiatives: Releasing Time to Care, LEAN, Safer Healthcare Now, Attendance Management, etc.

As depicted, Nursing Management experienced a shift from a clinical to an administrative focus with significantly expanded scope. Both literature and the stakeholders consulted report that this shift has had undesired consequences in the key areas of: patient care service delivery, staff management and work unit culture, as well as Nurse Manager job satisfaction.

Nurse Managers interviewed in this review reported that they feel a strong requirement for accountability and responsibility in their roles with little authority. Their roles have become increasingly complex with growing (and what they identify feels like "unmanageable") spans of control. The relevant findings related to Nurse Manager span of control are listed below.

- Nurse managers have an average of 99 direct reports provincially, where some Nurse Managers are required to supervise 200 staff who may work at more than one site, and represent a number of different job categories outside of Nursing (such as: Rehabilitation professionals, Social Workers, other disciplines, and support staff). Managers have limited ability for mentoring, coaching, supervision and staff development with this number of direct reports.

- Adherence to nursing practice standards is critical to quality patient care, as well as continual updating of research-based standards. Nurse Managers must ensure they are aware of practice changes, and ensure staff implements them in a timely manner.

- Increasingly, Nurse Managers have "out of discipline" staff (i.e. non-nurses) reporting to them. For many of these staff, there is a further requirement to have some knowledge of practice standards. This can be a challenge for Nurse Managers, particularly, where the Professional Practice Leaders per discipline are not readily available.

- With an increase in the complexity of patient care, and reliance on the high number of new and international educated nursing graduates, significant time is required for orientation and ongoing development of these staff. Managers reported that due to a lack of unit based clinical educators, these responsibilities fall to them, and they have insufficient time for this activity.

- Nurse Managers spend significant time performing non-managerial duties, which previously were done by clerical support. Many support roles have been eliminated with budgetary challenges in the 1990's, and the impact is limited resources to support nurse managers.

- Strong and growing provincial emphasis on excellence, quality, safety and putting the patient first, while commendable, has resulted in a multitude of initiatives (Releasing Time to Care, LEAN, Safer Healthcare Now, and IHI initiatives). There are limited resources for implementation support, which can impact the Nurse Manager who is required to champion, if not lead, initiatives. The change and implementation requirements are time consuming, and there are too many to be managed effectively, and to ensure sustainability. Nurse Managers say "everything is a priority".

- Nurse Managers are increasingly required to work longer hours and return to work outside of normal working hours, to assist staff with clinical and staffing issues. This creates work/life imbalance, and has a significant impact on manager job satisfaction.

- Many Nurse Mangers have limited educational preparation for the administrative components of their role, and there is limited opportunity for comprehensive orientation or ongoing professional development. Compounding this issue, many Nurse Managers are inexperienced: nearly 50% have less than 5 years experience; in large urban areas, 20% have less than 1 year experience.

Compounding these challenges, there is significant forecasted turnover for Nursing Management and limited attraction to the role. SAHO data demonstrates that 39% of Nurse Managers are eligible for retirement over the next 5 years. Nursing Management demographics show significant considerations:

- Number of Nurse Managers over age 51 (and eligible for retirement) is significant, and is evenly distributed: 45% in urban RHAs, 51% in non-urban RHAs, and 41% in the northern RHAs; and

- Nurse Managers with more than10 years in the role are considering retirement.

The consultation findings indicate that little or no succession planning is underway. Urban centres are somewhat optimistic regarding succession planning; in non-urban settings, Nurse Managers felt that few staff are interested in this role. Nurse Managers identified frustration that previous reviews have not brought discernable change. Overall, this employee group feels powerless to effect change.

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Implications

The key challenge is to address 'freeing up' Nurse Managers' time so that they can apply more clinical focus. Reversing the undesired consequences of the Nurse Manager shift from predominantly clinical to predominantly administrative is a challenging and complex task for any jurisdiction, and no less for Saskatchewan, which has dispersed facilities, large geography, and limited resources to draw upon.

In order to enable the Nurse Manager to play a stronger and available leader role for staff and patients, the management model will have to focus on how the role can be re-scoped to a more manageable span of control.

Adopting a Transformation Roadmap - Opportunities for Saskatchewan

Thinking of the future

Implicit in the change opportunities is the need for courage. Leaders at all levels, (political, provincial and RHAs) must avoid the false notion that the Saskatchewan health sector is too unique, different or constrained to adopt innovative and creative solutions that are working elsewhere. The inevitable conclusion of this report is that the future of Saskatchewan's health system lies with adopting new ways of doing business. The opportunities developed have been analyzed and provide the basis for recommendations. Looking ahead, Saskatchewan's corporate health management structure should begin to adopt new operating models designed to provide a balance between local responsiveness and stronger, more centralized management structures designed to:

- Create economies of scale through the consolidation of repetitive transactional functions occurring across all RHAs;
- Promote standardized practices for current and new work processes to enhance effectiveness;
- Attract and retain required staffing for 'hard to find roles' to avoid the current and anticipated workforce challenges in many of the RHAs; and
- Provide consistent strategic leadership at a province-wide level.

This management transformation is intended to deliver increased value, address sustainability challenges across numerous smaller health regions, and, once in place, cost the system less. A further benefit gained is that the RHAs come together as a common enterprise, rather than a collection of independent entities. The future reduced costs can be used as an offset to the required investment to support the change and, in time, can be re-allocated to the patients and communities of Saskatchewan.

In order to create this future state, there are two types of opportunities facing Saskatchewan:

1. Transformational opportunities, which promote a different way of doing business and represent large-scale change; and

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2. Enabling opportunities which exist at either or both the Ministry and RHAs, and provide:
   i) Improvements to the current state that should be undertaken;
   ii) Interim solutions between current and future state;
   iii) Foundation for transformation requirements to 'do business differently'; and
   iv) Transition requirements to support implementation of transformation opportunities.

While the transformational opportunities required additional work as concepts before they could be valuated and a preferred direction determined, it was agreed that the enabling opportunities were appropriate and they were transitioned to recommendations. Both transformational and enabling opportunities along with recommendations are presented in the next section of this report.

Transformational Opportunities

Given the magnitude of change in transforming Nursing Management and Corporate Administration, more than one way exists to bring about change. The table below presents the options examined for the transformational opportunities (details on the options can be found in the Appendix).

Area		Transformational Opportunities and Respective Options for Value Analysis
Nursing Management		▪ Determine whether a Clinical Front Line Leader or Clinical / Administrative Leader role is preferred based on the following considerations: – Clinical / Administrative Leader - Managers would continue in their current role, but with additional support to eliminate non-managerial tasks from their accountabilities, freeing up significant time for clinical leadership – Clinical Leader - requires majority of administrative tasks to be removed from Nurse Manager role. To facilitate this, significant managerial supports would be required organizationally to perform these administrative duties
Corporate Admin Back-Office Service Integration	HR	▪ Managed Service for HR delivered across three zones (hubs) in the province that provides transactional and strategic management HR services across the province OR ▪ Shared Service organization (Newco) that provides standardized transactional and strategic management HR services for all RHAs
	Finance	▪ Managed Service for Finance across three zones (hubs) in the province that provides transactional Finance services for RHAs OR ▪ Shared Service organization (Newco) that provides transactional Finance services for RHAs
	Supply Chain	▪ Explore options to centrally manage, coordinate, and / or deliver supply chain functions, such as: – Planning, Procurement, Logistics and Distribution, Inventory Management, Payment

To determine the highest value change option for Saskatchewan, a valuation framework with four value drivers and variable weighting (see below) was developed and validated with the Ministry to assess and determine the preferred transformation options before moving to recommendations. When considering each opportunity option, we examined the impact on Patient Focus, Workforce Focus, System Focus, and Feasibility.

Valuation Framework

Patient Focus (40%)
(Positively Impact Patients' Experience)

- Contributes to improving the patient's experience with the health system by measuring, reporting, analyzing, establishing and meeting / exceeding expectations about quality and coordination of services delivered across the continuum of care
- Supports customer engagement including clear service delivery expectations and targets for improved customer engagement and satisfaction
- Supports customer convenience (less travel, faster access)

Workforce Focus (20%)
(Generate Better Workforce Environment / Deployment / Recruitment)

- Strengthens people and talent management strategies (succession, recruitment, retention, development, competency development) to increase consistency across Province
- Builds workforce capacity to support system-wide adoption of a culture of efficiency, effectiveness, and patient-centred approaches that focus on creating more value for customers
- Strengthens provincial people strategy that supports allocation of resources to areas of high need
- Promotes adoption of alternative service delivery model that addresses sustainability and quality concerns

Preferred direction

System Focus (20%)
(Generates higher value delivery systems)

- Promotes reduction in current operating costs that can be reallocated to higher value service models through use of evidence and approach to improve access, efficiency, patient and provider satisfaction, etc.
- Addresses sustainability challenge and improves current service delivery and levels
- Supports stronger performance management, transparency and accountability that focuses on measurement and reporting, service delivery and achievement of outcome targets and strategic directions
- Increases provincial coordination and standardization

Feasibility (20%)
(Potential to implement)

- Ease of implementation (change management requirements)
- Cost to implement, including time to achieve return on investment
- Timeliness (length of implementation)
- Political considerations (elected officials, public, MOH)

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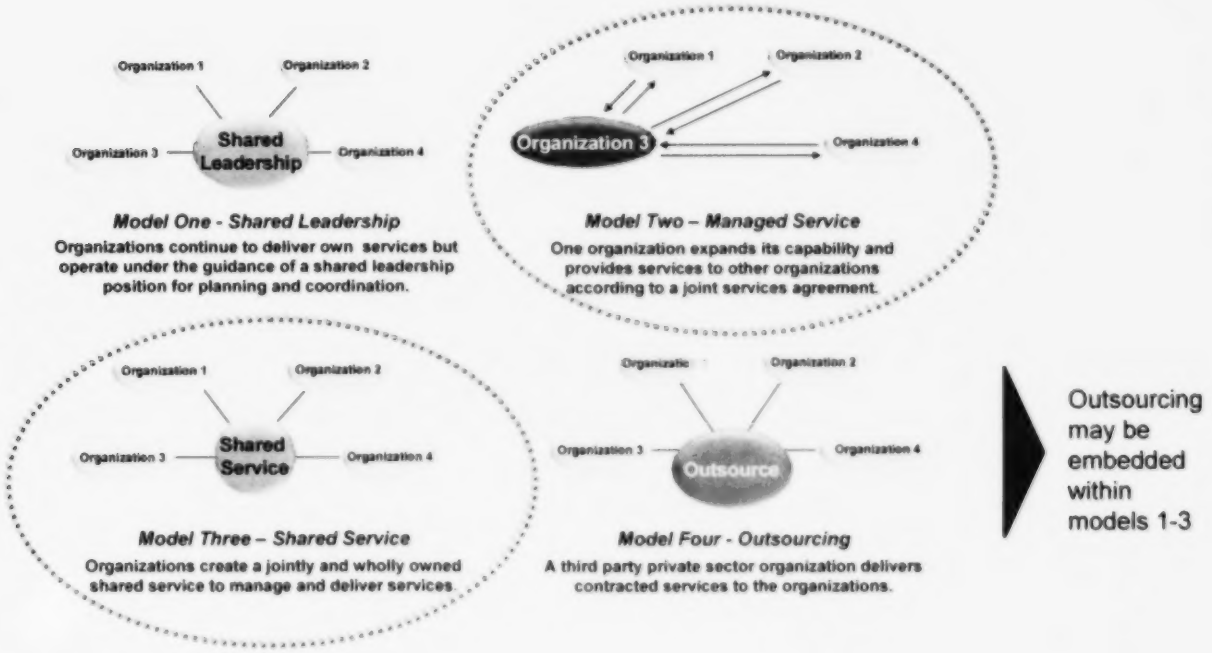
Administrative Services Opportunities: Back-Office Service Integration

Health organizations across the country are examining alternative service models to acquire cost savings for reinvestment. Multiple jurisdictions in Canada are exploring alternative service delivery models for corporate and support services. The graphic below outlines four different models of alternate service delivery, where potential savings and increased capacity can be realized. Given the higher degree of benefits realized through greater transformation, this review focused on the Managed and Shared Service models.

Alternate Service Delivery Models to Support Service Integration


Organization 1
Organization 2
Organization 3
Shared Leadership
Organization 4
Model One - Shared Leadership
Organizations continue to deliver own services but operate under the guidance of a shared leadership position for planning and coordination.
Organization 1
Organization 2
Organization 3
Organization 4
Model Two – Managed Service
One organization expands its capability and provides services to other organizations according to a joint services agreement.
Organization 1
Organization 2
Organization 3
Shared Service
Organization 4
Model Three – Shared Service
Organizations create a jointly and wholly owned shared service to manage and deliver services.
Organization 1
Organization 2
Organization 3
Outsource
Organization 4
Model Four - Outsourcing
A third party private sector organization delivers contracted services to the organizations.
Outsourcing may be embedded within models 1-3

The starting point, scope, and pace of service integration depend on the capacity and appetite for volatility, and the resources available to implement change. Supply Chain is a common starting point as the business case (and savings) often supports adoption of other shared services (such as Finance, HR). Examples of service integration considered in Canada and abroad include:

- Corporate Functions: HR, Finance, IT, Legal, Insurance (procurement), Information / Privacy, Infection Prevention and Control, Internal Audit, Physician Leadership and Medical Affairs, Communications; and
- Support Functions: Supply Chain, Facilities, Biomedical Engineering, Laundry / Linen / Housekeeping, Health Information Management, Food Services, Central Sterilization and Reprocessing.

In addition to corporate and support functions, service integration is also occurring in clinical programs and regional health structures:

- Clinical service integration and coordination within and across RHAs to ensure safe, sustainable (i.e. spending, workforce), high quality care that is accessible; and
- Regional Health Structures continue to evolve as seen most recently across Canada in Alberta (9 to 1) and New Brunswick (8 to 2) and in other jurisdictions such as: Denmark (15 counties to five health regions) and the UK (28 strategic health authorities to 10, and 350 Primary Care Trusts to 152).

Key value drivers for such service integration include:

- Saving costs via centralization, process standardization, and implementation of leading practices;
- Capital / cost avoidance (replacing dated information systems, infrastructure);
- Increasing service quality and safety – customer focus with clear accountability for performance;
- Refocusing resources (managers and staff within areas) to value-add activities; and
- Improving sustainability – financial (operating / capital), workforce, service quality.

For Saskatchewan, irrespective of the model selected (i.e. Shared Service versus Managed Service), the following are key requirements needed to support the change:

- Further business case development is required to validate savings and investment requirements. Savings and cost estimates are high level and based on other jurisdictions' experiences. They are provided for the purposes of model valuation.
- The role, mandate, structure, and governance of SAHO need to be examined in the Shared Service Model.

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Recommendations

Transformational Recommendations (by area)

Nursing Management

Recommendation	Rationale
1. Introduce supports to the current Nurse Manager role that will allow increased focus on the patient and staff requirements.	Managers reported that the most satisfying components of their role are the impact they can make on patient care, and staff development. Appropriately assigned managerial tasks can still be accomplished within the current role where non-managerial clerical type tasks are removed from their accountabilities. Based on the option valuation approach, the current Clinical / Administrative Leader was the preferred option (over the Clinical Leader) because it requires less of a culture change and is less costly to devolve non-clinical activities. The alternate Clinical Leader option required significant culture change and investment (one time and operating). While both models need investment to support Nurse Manager effectiveness: ▶ The preferred model (Clinical/Administrative Leader) has approximate costs of $500k in capital and $2.5M to $3.5M annual operating costs (which have been arrived at by estimating the capital and operating costs required to support this model); ▶ The Clinical Leader option (not selected) requires same capital cost ($500K), an additional upfront change management investment of $1M, and higher annual operating costs of $5M-$7M (because this model has another level of management). **Key considerations for implementation:** Required investments for the preferred option may be supported by: 1.Reallocation of resources through pending service integration changes and associated savings, and 2.Examination and potential realignment by RHAs of organizational structures at the VP and Director levels across system (as there are 45+ VPs and 400+ Directors in all corporate and clinical sectors that account for $7M and $38M in annual compensation spend system-wide. Note: Changes to organization structure should be directed by RHA executive leadership based on their respective organizational requirements.

Supply Chain, Human Resources, Finance

Recommendations	Rationale
1. Establish a single Provincial Shared Services Organization for Supply Chain, Human Resources and Finance functions, which will require the following: a) Detailed service model design, and business case, implementation plan, and transition support focused on people, work process, technology, and change management requirements); b) Defined governance, mandate, role, organization and operating structure, for the Provincial Shared Services Organization; and c) Alignment / integration plan for SAHO functions and staffing within the mandate of the Provincial Shared Services Organization.	Based on the valuation of both Shared and Managed Service options, the preferred option is a Shared Service Organization Model. This result was driven by higher value weightings in Workforce (i.e. capacity / sustainability) and System (i.e. savings for reinvestment, sustainability, coordination / standardization) quadrants. Other considerations include: ▶ Enhanced economies of scale and scope through increased integration, and enablement of system / process standardization (aligned with leading practices); and ▶ Shared Service Model is more feasible politically from the perspective of RHAs (compared against the managed service model). Potential savings from operations in this model will yield the greatest dollar reinvestment available for reallocation to enhance the patient experience. Savings estimates as percentage of operating costs are 14-20% for a shared service model versus 12 – 17% a managed service model – with a payback of 4 to 5 years. Estimates are high level and based on Deloitte's experience in other organizations / jurisdictions. **Key Considerations:** Additional time / effort / cost may be incurred for implementation through process / system standardization and development of a gain sharing model across 14 entities (i.e. ensuring appropriate allocation of potential savings across all participating organizations). Investment estimates (capital and transition support) as percentage of operating costs for Finance, HR, and Supply Chain are similar over five years: 19-26% for a shared service versus 17-24% for a managed services. Estimates are high level and based on Deloitte's experience in other organizations / jurisdictions. As the future service delivery model is designed for a shared service organization in Finance, HR, and Supply Chain (and the associated scope of services are determined), the following considerations will need to be addressed: ▶ The mix of services to be provided in the shared service entity (a range of transactional services that are duplicated across regions, selected strategic services, and those services currently provided by SAHO. ▶ Overlap during the transition period to a single Shared Services Organization – in all organizations. ▶ SAHO does not currently have the capacity / capability to take on these shared services. ▶ Stakeholder consultations revealed that SAHO's current structure and governance model is limiting the value SAHO could potentially provide to its member organizations (i.e. quality of service, scope) – and would need to change irrespective of whether or not SAHO assumes an expanded role.
2. Accelerate selection and implementation of a single HRIS for the province (which will support Provincial Shared Services Organization).	SAHO has already engaged in a collaborative process with RHAs to formulate a business case for a provincial HRIS. Documented benefits include: supporting the reduction of manual, labour intensive work processes, and increasing process standardization, improving data quality.

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General Administration

Recommendations	Rationale
1. Realign executive and management structures at the RHA level, with a focus on consolidating executive roles and/or shared leadership roles where appropriate.	As the province moves to a Provincial Shared Services organization, RHAs should determine the most appropriate executive structure required in its corporate areas – where non-urban RHAs may not require separate executive leadership roles in each area of HR, Finance, and IT. Further, many non-urban RHAs have 2 clinical executive leaders – which could be integrated given: 1) the recommended additional supports in place for Nurse Managers which should alleviate the identified span of control challenges; 2) inconsistency in clinical leadership ratio across the province (i.e. direct reports, budget, population served), and 3) potential benefits of integration at the VP level across clinical programs.
2. Increase physician leadership roles across the province, with particular emphasis on increasing and establishing a standardized FTE allocation (i.e. 0.5 FTE to 1 FTE) for Senior Medical Officer (SMO) roles for non-urban regions.	Physician leadership roles in non-urban RHAs are highly variable in terms of allocation. Increased leadership is required to support change and accountability requirements.

Information Technology

Recommendations	Rationale
1. E-Health council should prioritize its development of the eHealth strategic plan and have in place by Dec. 01, 2009 (to enable and cascade operational requirements at the provincial and RHA levels).	Supports the need for continued and enhanced focus on the eHealth agenda for Saskatchewan. Advancing the eHealth agenda will require continued and potentially increased investment to realize the benefits of an e-HR. Enhances and standardizes service delivery structure for IT services across RHAs. Maintains pivotal role for HISC related to eHealth strategic planning and implementation. Given the range of current service models across RHAs, IT delivery (managed service, outsourced), there is a need to determine best go-forward provincial service strategy for IT at the RHA level. Additional review is required as the scope of this review could not include this level of additional work and detail.
2. Determine RHA requirements to advance e-HR agenda, as well as RHA ongoing IT requirements to maintain business and clinical requirements.	
3. Determine preferred service delivery structure for IT at the RHA level that focuses on the following options: a) HISC as an expanded service provider; b) A Managed Service structure that may chose selective outsourcing for commoditized IT functions (such as data centre, help desk); c) A Shared Service structure that may chose selective outsourcing for commoditized IT functions (such as data centre, help desk); other structures; d) Combination of the above options	
4. Secure and stabilize funding for both the provincial e-HR requirements and RHA implementation requirements.	

Enabling Recommendations

Enabling recommendations are provided by area, and should be staged to support the transformational recommendations. Staging of enabling recommendations will vary; some will precede, parallel or follow transformational recommendations.

Nursing Management

Recommendations	Rationale
1. Establish a provincial recruitment program for skilled nursing staff.	Currently, most Regions are engaging in recruitment activities and competing for the same staff. The outcome of this in the current regional delivery system is duplicative activity in addition to significant workload for busy Human Resource Departments and Nursing Managers. Will support smaller regions that are taxed to support the growing efforts in this area. This should be incorporated into the Provincial Shared Service Organization – once established.
2. Provide technology supports, such as increased access to printers, Telehealth, wireless laptop computers, PDAs (Blackberry), and desktop videoconferencing.	There is need to ensure the front line managers are enabled for enhanced effectiveness. Such supports are for onsite effectiveness as well as off site/unit responsiveness for managers who have to travel between sites/units.
3. Develop provincial service improvement teams that can travel to regions to support: a) Information and practice sharing; b) Regional project implementation support; c) Cross region/province collaboration; and d) Change initiative coordination.	To provide increased support at the regional level for standardized implementation – where areas of focus / support could include development or implementation of: ▶ Clinical practice guidelines; ▶ Standards of care; ▶ Quality / patient safety policies; and ▶ Other provincial initiatives (i.e. releasing time to care).
4. Develop a Nursing Management Resource Team at provincial level that supports: a) Organizations with medium to long term manager vacancies; b) New hire (1 to 3 months) transition (coaching); and c) Ongoing management education and professional development opportunities.	Provincial resource group that extends across province to support nursing management requirements where there are identified challenges will alleviate pressures at smaller regions. Cadre of strong Nurse Managers across province who could fill these roles. Many managers are nearing retirement; a role of this nature would retain their expertise in the system. Providing current managers with support for orientation, ongoing development, and relief so that managers could access professional development opportunities off-site, will increase job satisfaction and enhance recruitment into the role.

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Recommendations	Rationale
5. Identify potential management-staff compression issues for the Nurse Manager role, which will include considering job descriptions, compensation levels, and Joint Job Evaluation (JJE) classifications.	Recent compensation adjustments for Nurse Managers (as a result of requirements to align with the recent SUN agreement) may not be sufficient to address the "total compensation" gap - when shift / weekend differential, responsibility pay, overtime and education allowance are considered for frontline nurses – suggesting a required focus on job classifications MCP4 and MCP5. There is a need to identify staff-management compression issues, and ensure that Joint Job Evaluation (JJE) for Nurse Managers accurately reflects the role complexity.

Finance

Recommendation	Rationale
1. Audit mapping of payroll data to RHA financial accounts.	Data challenges observed and experienced in this review process suggest that the RHAs are not following standardized mapping. The benefit for the Province will be stronger consistency for future comparisons.
2. Conduct an MIS audit to enhance the quality / comparability of information across organizations.	Data challenges observed and experienced in this review process suggest that an audit of reported data is required.

Human Resources

Recommendation	Rationale
1. Establish a talent management strategy for managers (across all disciplines), that focuses on recruitment and retention practices and incentives, learning and development of current and future cadre, succession planning, and performance management.	To provide learning and development opportunities for current and future management / leader cohort.. Improvement opportunities include: ▶ Mandatory orientation for new managers; ▶ Increased management / leadership courses for current managers; ▶ Increased networking opportunities for managers across Regions; and ▶ Developing and / or supporting the cohort of new managers to enter the system. This should be incorporated into the Provincial Shared Service Organization – once established.

Recommendation	Rationale
2. Align provincial workforce strategic planning initiatives with upcoming provincial clinical service planning (linked to current provincial work underway to establish sustainable service delivery models across the health care continuum, and in particular in rural and northern Saskatchewan).	RHAs have reported difficulty recruiting and retaining qualified clinical staff (including physicians) across urban, non-urban, and remote areas. In extreme situations, this has resulted in service closures – either periodically and in some cases permanently. Future workforce planning for all areas / disciplines (i.e. clinical and non-clinical) should be aligned with a renewed provincial clinical service delivery redesign. The types and distribution of services need to align with evidence-based population health needs, Patient Experience review findings, and workforce sustainability considerations (available workforce, quality of care, patient safety and cost). Clearer defined service model across Saskatchewan should be aligned to the provincial workforce planning to support new models of service.

Telehealth

Recommendation	Rationale
1. Expand the Telehealth clinical programming across the province through the following mechanisms: a) Assess business case of Telehealth expansion on a clinical service / program basis that will enhance access and reduce travel requirements and costs for patients and families; b) Develop provincial scheduling solution for Telehealth sessions and corresponding work processes to increase service coordination and ease of access; and c) Develop provincial clinical adoption strategy that includes resources to support transition.	Increased Telehealth programming for clinical care will: ▶ Enhance patient access and convenience, and reduce travel requirements; and ▶ Support alternative clinical service delivery redesign.
2. Expand Telehealth or other mechanisms (such as desk-top video conferencing and video archiving of educational sessions) in rural communities for administrative and training and development purposes considering enhanced patient access, reduced travel and savings in travel and accommodation for staff and patients.	Increased application of Telehealth or other mechanisms will reduce the need to travel to meetings or educational events, provide easier access to for clinical, educational, and administrative functions, which will promote greater end-user adoption while mitigating the requirements for other more costly telehealth infrastructure.
3. Explore business case for future clinical expansion that includes: a) Advanced applications of Tele-home care; b) Tele-monitoring to support enhanced access considerations; and c) Piloting new applications in rural/northern communities and link to advancing chronic disease management strategy.	Increased Telehealth programming for clinical care will: • Enhance patient access and convenience; • Reduce travel requirements; and • Support alternative clinical service delivery redesign.

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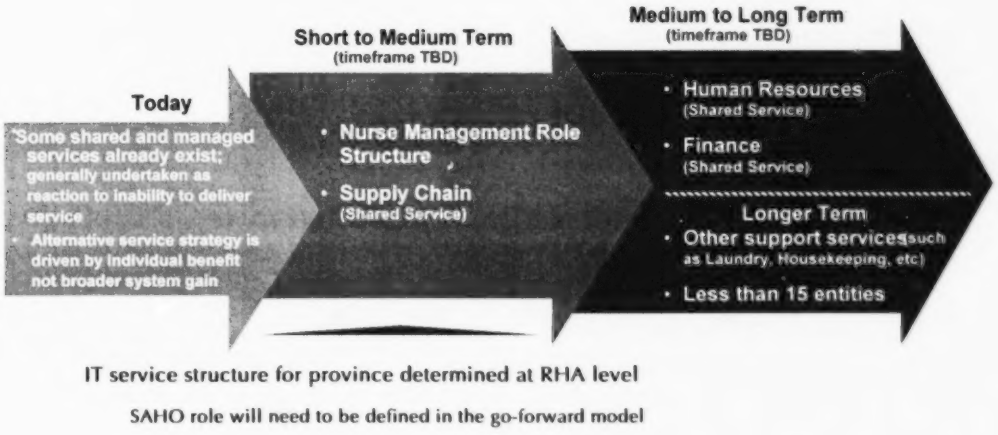
Recommendations staging

The diagram (below) provides a framework to guide transformation to service integration over the next 5 years. This change journey requires Saskatchewan's health care leaders and providers (i.e. RHAs and SCA) as well as political leaders to shift their perspective from an organization-centric to a system view.

In the short to medium term, the initial focus for service integration should be on supply chain. Commonly, across other jurisdictions, supply chain is the starting point and can provide a foundation to support medium to longer-term service integration opportunities such as Finance and HR. The future role and mandate of SAHO will need to be considered in parallel. At the same time, changes to Nursing Management should begin as well. Provincial and RHA requirements for IT service delivery should be considered and factored into the future state planning.

Framework to Guide Transformation


Today
Some shared and managed services already exist; generally undertaken as reaction to inability to deliver service
Alternative service strategy is driven by individual benefit not broader system gain
Short to Medium Term
(timeframe TBD)
Nurse Management Role Structure
Supply Chain
(Shared Service)
Medium to Long Term
(timeframe TBD)
Human Resources
(Shared Service)
Finance
(Shared Service)
Longer Term
Other support services (such as Laundry, Housekeeping, etc)
Less than 15 entities
IT service structure for province determined at RHA level
SAHO role will need to be defined in the go-forward model

Savings achieved through Supply Chain can enable key Nurse Manager support requirements such as clerical support, technology enablement, and professional development. Longer-term transformational activities may also include the examination of other key support services, and greater integration across regional structures in the province.

It is important to note that the selection of preferred models was supported by high level investment and savings estimates. Significant work will be required related to the detailed design and business case for shared services in the province across Finance, HR, and Supply Chain – including the review and determination of SAHO's role going forward.

Summary

The primary question in the Administrative Review was whether Saskatchewan's current health system is 'over' or 'under' managed. While the province's relative level of resourcing for combined Administrative areas (which includes General Administration, Finance, Human Resources, and Information Technology) is lower compared to Canadian jurisdictions, there are a number of considerations that provide important insights:

- Low relative resourcing is driven by General Administration and IT, and does not necessarily represent efficiency, effectiveness or value.
- While General Administration spend is lower compared to Canadian jurisdictions, Saskatchewan has greater relative spend on board and executive costs, which leaves fewer resources for key General Administration support functions such as strategic planning / decision support, quality / risk management, and patient safety.
- Lower IT resourcing translates to insufficient resourcing across RHAs, where IT is not able to meet the business requirements in many organizations, and will be challenged to support the provincial eHealth strategy going forward.
- Finance and Human Resources have higher relative resourcing compared to Canadian jurisdictions. These functions are largely transactional in nature, particularly in the non-urban regions, and the needs of internal customers (i.e. managers / employees) are reportedly not being met.
- Current corporate management model is not sustainable from a workforce perspective. In particular, Finance, Human Resources, and IT functions are experiencing and anticipating recruitment and retention challenges of qualified leadership and frontline staff.
- Economies of scale are challenged given the duplication of transactional functions across 14 service provider organizations.
- Lack of consistent strategic leadership is evident across provider organizations.

In simple terms, while Saskatchewan is spending less than other Canadian jurisdictions on an overall basis in its corporate management of the health system, it is receiving questionable value for money. This is not an outcome of the leadership; it is the health regions configuration that limits the ability for significant gain. In addition, the sustainability challenges experienced by many of the RHAs raise a further question of viability. All of this points to a strong need to reconsider the current regional structure, an area outside the scope of this review. Meanwhile, the Province does not need to stand still. Regional Health Authorities can do things differently in the interim. The recommendations in this report are not about changing the business, but rather conducting business differently so that the system is more efficient, effective and sustainable.

Leading and sustaining change should be a priority for Provincial Leaders, Senior Management and Boards of Regional Health Authorities. Given the magnitude of transformation recommended in this report, 'making it happen' is no small task. However, inaction is not an option. At the heart of the recommended change, the goal is to generate new service models that consolidate centres for transactional activities, creates stronger more centralized strategic management, and maintains local support at the RHA level. The outcome of this transformation is a more cost effective delivery system that delivers higher value, addresses the growing sustainability challenge across numerous smaller regions, and, once in place, costs the health system less.

Success is dependent on accepting change and gaining further clarity on what the new system will look like and the detailed support requirements. The good news is that precedents exist to achieve this future state. However, strong desire for change alone will not bring success. Without well planned and supported execution, breakthrough thinking falls apart, and little to no value is added. As the province and RHAs work as partners to change and improve the way they conduct business, it is imperative to think hard about execution. This means heeding lessons from other jurisdictions and tailoring them to Saskatchewan. It also means understanding what services the regions need and how they need to be delivered to be acceptable. Collaboration is key. The Province should look to partners in other jurisdictions and sectors. Most importantly, the Province and the multiple stakeholders should begin to view the Regional Health Authorities as a common enterprise, rather than a collection of independent entities.

The findings and corresponding recommendations provide a future vision for Saskatchewan. A detailed strategy for execution which bridges theory and practice will help the province get there. For Saskatchewan to be successful in this transformation, investment is required along with strong leadership and performance management.

Appendices

Transformational Opportunity Option Descriptions

Nursing Management Opportunity: Nurse Manager Role Redesign and Enablement

The national trend for Nursing Management, also evident in Saskatchewan, has seen a shift from clinical focus to an administrative focus with significantly expanded scope. The key challenge and goal is to '"free up" Nurse Managers time so that they focus more on the patient care accountabilities associated with their role, and are available to staff for mentoring, coaching and staff development. The two options developed focus on different approaches to adjust the Nurse Manager role.

Option 1: Clinical / Administrative Leader

Managers continue in their current role, with additional support that allows them to shift the focus from administrative to more clinical in nature. The goal is to allow Nurse Managers to refocus on patient care and staff leadership. This shift is achieved through the assignment of appropriate corporate / administrative tasks and functions to the most appropriate level of staff in the correct organizational area, and other key enabling supports, such as:

- Additional clerical support to facilitate relinquishment of non-managerial responsibilities to a more appropriate level of employee;
- Nurse Management Transition Resource Team, to assist with orientation and mentoring of new managers;
- "Out-of-Scope" Assistant Patient Care Manager or Clinical Supervisor to relieve some of the managerial burden for managers, and facilitate a mentoring process for those interested in nursing management positions in the future;
- Technology enablement, to facilitate timely communication between staff and managers when managers are required to be off-site; and
- Enhanced support from Finance and HR to ensure staff from these areas perform non-managerial transactional activities associated with these corporate areas...

Option 2: Clinical Leader

Nurse Managers would relinquish most of their administrative tasks, and assume a clinical leader role (similar to ward sister in United Kingdom model), thereby shifting to a full clinical focus. Following the UK model, a new level of administration would be required between the Director and Nurse Manager level (Matron as in the UK or likely another name) for every three to four clinical Nurse Managers. The Clinical Nurse Manager would be responsible for:

- Budget compliance for the unit;
- Staff mentoring and supervision;

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- Daily staff scheduling assignment;
- Patient care coordination; and
- Patient and family concerns.

The new level of management (called the 'Matron' in this review) would be responsible for:

- Budget development and monitoring for group of units;
- Business planning;
- Scheduling;
- Attendance management;
- Performance appraisals, hiring, firing, labour relations;
- Liaison with support services and departments to ensure clinical needs are met;
- Equipment procurement;
- Policy research and development; and
- Committee attendance.

Administrative Services Opportunities: Back-Office Service Integration

Based on our review of Administrative functions in Saskatchewan, which revealed higher levels of resourcing for Finance and HR (compared to other jurisdictions), and workforce sustainability and service quality issues, Finance and HR are key candidates for service integration. In addition, Supply Chain is added to this opportunity given its linkage with Finance functions (i.e. Accounts Payable), and the potential savings through centralization of Supply Chain across the Province. Experiences from other Canadian jurisdictions demonstrate that Supply Chain integration supports the business case for further service integration across Finance and HR – and beyond. Two options were considered for back-office service integration:

Option 1: Shared Service

Shared Services involves the creation of a new entity for the province, and builds on the foundation established by SAHO. It would support transactional (and some strategic) Finance, HR, and Supply Chain functions / activities. Shared Services entity could be structured with the following components:

- *Service Centre:* Transactional activities are centralized through a Service Centre (i.e. HR self-service, HR administration, A/P, GL, standardized analytics / reporting)
- *Centres of Expertise:* Centralized experts supporting key strategic functions, providing consulting and strategic advice to business advisors regarding labour relations, total rewards, talent acquisition and development, disability management, business planning
- *Local Business Advisors:* Local support would be available for Finance and HR across RHAs, aligned by organizational structure, and enabling strong client relationships, deep business knowledge, and cascading standardize work processes and solutions at the client organization

An ERP system and operational process standardization will be a key enabler to support integration. Similar to Option 1, Supply Chain is sequenced first; Finance and HR systems / process standardization could occur in tandem. The approach to determine estimated savings is similar to the Managed Service option; however, the estimated magnitude of

savings is greater in a Shared Service due to increased consolidation, standardization, and critical mass in the Shared Service model.

Option 2: Managed Service

A Managed Service model would entail the creation of 3 managed service hubs or "zones" (i.e. North, Central, South) for Finance, HR, and Supply Chain functions / activities. In this option, each of the three service providers would rollout their respective service delivery models currently, which may include a transition to a model that is a hybrid of centralized and local support (see table below). An ERP system and operational process standardization at the zone level will be a key enabler to support integration. Supply Chain would be sequenced first, with Finance and HR systems / process standardization occurring in parallel.

Savings estimates for Supply Chain are based on integration of procurement functions, and potential savings associated with increased product standardization and group purchasing. Aspects of end-to-end supply chain would be considered in design / business case development in year 1.

Savings estimates for Finance and HR are based on comparing the relative performance of service providers (i.e. RHAs) in the system versus performance of potential service hubs in the system.

For both options, there are several functions / activities across HR, Finance, and Supply Chain that can be considered in either a managed or shared services model. The table below indicates which activities would be part of the managed / shared services model and which would be retained locally by independent health care organizations.

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Function / Area	Sub-Function / Activity	Considered for:	
		Managed Service (North, Central, South Zones)	Shared Services
Finance	General ledger		
	Asset Management		
	Accounts Receivable		
	Accounts Payable	**Yes**	
	Payroll		
	Reporting / Analytics (some)		
	Finance Business Advisors	**No (Retained Locally)**	
	Financial Stewardship – CFO		
Human Resources	Compensation / Benefits		
	Attendance Mgmt		
	OH&S		
	Organizational Development	**Yes**	
	Employee Relations / Labour Relations		
	Talent Management (recruitment / retention, workforce planning, performance management)		
	HR Business Advisors	**No (Retained Locally)**	
Supply Chain	Planning / Procurement	**Yes**	
	Distribution & Logistics	(Procurement / Sourcing would be centralized across system in both models – other supply chain functions would be considered in design / business case phase)	
	Inventory Management		
SAHO	Payroll / Pay Processing	**No**	**Yes**
	Benefits Administration		
	GPO		
	Labour Relations		
	Provincial programming (i.e. Occupational Health and Safety, Organizational Development)		

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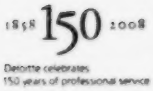

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